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ABSTRACT

This paper describes a conjoint, collaborative training and supervision model designed for undergraduate psychology trainees. The Paraprofessional as Companion Therapist (PACT) program provides an internship experience for undergraduates who work directly as outpatient therapeutic companion-aides with university counseling center eating disorder clients. Trainees are closely supervised by two doctoral level psychologists: the onsite therapist and the academic intern supervisor. Supervision is done conjointly using a group framework and case presentation format in which client contact is monitored and prescriptive interventions are provided. Client outcome measures are used to measure trainee's effectiveness and response to supervision. Paired responses to a client change scale compares client and trainee ratings of therapeutic change. (Forty-four references are included, and data are displayed in one table and three figures.) (Author)

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Conjoint Supervision of Undergraduate Trainees Working with Eating Disorder Clients

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ABSTRACT

This paper describes a conjoint, collaborative training and supervision model designed for undergraduate psychology trainees. The Paraprofessional and Companion Therapist (PACT) Program (Lenihan & Kirk, 1990) provides an internship experience for undergraduates who work directly as outpatient therapeutic companion-aides with university counseling center eating disorder clients. Trainees are closely supervised by two doctoral level psychologists: the on-site therapist and the academic intern supervisor. Supervision is done conjointly using a group framework and case presentation format in which client contact is monitored and prescriptive interventions are provided. Client outcome measures are used to measure trainee effectiveness and response to supervision. Paired responses to a client change scale compare client and trainee ratings of therapeutic change.

Clinical supervision is uniformly regarded as a central component in the training of counselors and other helping professionals. While notable progress has been made in the development of theoretical and innovative models of supervision (Goodyear & Bradley, 1983; Hess, 1980, Stanton & Stanton, 1986), recent reviews of the supervision literature (Hansen, Robins, & Grimes, 1982; Lambert, 1980; Lambert & Arnold, 1987; Loganbill, Hardy, & Delworth, 1982; Matarazzo & Patterson, 1986) indicate continuing emphasis on the framework of one-to-one supervision and a focus on the development and measurement of facilitative relationship skills of the supervisor, the trainee, or both. Supervision outcome research has also reflected these trends (Carifio & Hess, 1987; Gandolfo & Brown, 1987; Lambert & Arnold, 1987; Leddick & Dye, 1987; Russell, Crimmings, & Lent, 1984).

Little attention has been directed to alternative frameworks for supervision (Sansbury, 1982) or to the widely used practice of group supervision (Getzel & Salmon, 1985; Holloway & Johnston, 1985; Schreiber & Frank, 1983). One approach which does move beyond a focus on facilitative skills and also utilizes a group framework is the case presentation approach (Biggs, 1988; Holloway, 1988). However, rationales which support group models are scarce (Sansbury, 1982). Even more scarce are descriptions of collaborative models. Those previously described have recommended

a senior therapist/supervisor and junior trainee/leader as "co-supervisors" (Alpher & Kobus, 1988; Glenwick & Stevens, 1980) or described cooperative models in which two supervisors may share a practicum group setting or may supervise the same trainees on different client cases (Davis & Arvey, 1978; Martin & McBride, 1987; McBride & Martin, 1986). A notable exception is found in the arena of family therapy supervision where the use of collaborative teams and group framework is more commonly employed. This is often done with a team of trainees and supervisors acting together to observe, suggest interventions and even confer with a client family in session (Anderson & Rambo, 1988; Cade, Speed, & Seligman, 1986; Sperling, Handen, Miller, Schumm, Pirrotta, Simons, Lysiak, & Terry, 1986; Stanton & Stanton, 1986; West, 1984; Whiffen & Byng-Hall, 1982).

Evaluation of supervision approaches has tended to reflect the emphasis on one-to-one supervision and the familiar focus on facilitative skills. As a result, supervision effectiveness is almost always reported in terms of trainee impact. Lambert (1980) has recommended evaluation of supervision using criteria from several sources and has noted that the most successful outcome instruments are those designed to be used in actual counseling relationships. Few supervision studies consider the rather critical element of the client as a variable; fewer still include client outcome as a measure of supervision effectiveness (Goodyear & Bradley, 1983; Kagan, 1983; Poertner, 1986). While no one

denies the need for skills enhancement during supervision, the "proof of the pudding" remains client benefit (Matarazzo & Patterson, 1986).

The conjoint model of supervision presented here was designed to guide and implement an innovative training/treatment program (Lenihan & Kirk, 1990). The Paraprofessionals as Companion-Therapists (PACT) program paired previously trained and screened undergraduate paraprofessional interns with clinically diagnosed eating disorder clients being seen in therapy at the counseling center of a midwestern university. The interns served as "companion-therapists" (CTs) and provided twelve to eighteen hours per week of therapeutic companionship, empathic listening, problem-solving guidance and monitoring of client's progress. Clients concurrently received weekly intensive group psychotherapy with a feminist therapist with a cognitive-behavioral orientation (Boskind-White & White, 1983; Fairburn, 1985; Lenihan & Sanders, 1984; Mitchell, Hatsukami, Goff, Pyle, Eckert, & Davis, 1985). The counseling center therapist also served as clinical supervisor.

Conjoint Supervision Model

To complement this multidimensional, nontraditional treatment program, it has been necessary to devise an innovative and flexible framework for supervision of these beginning therapists. This model incorporates group supervision provided by collaborating professional supervisors who are jointly responsible

for the overall development of trainees and for positive client change. In addition to skills training and a focus on trainee development, a case presentation approach (Biggs, 1988) within a conjoint group framework has been used to build trainee skills in clinical observation and to directly involve them in assessment and treatment planning. To complement the overall treatment approach, strategies consistent with a cognitive behavioral approach to supervision (Kurpius & Morran, 1988) have been incorporated. The authors have added additional components to the supervision experience designed to encourage the development of assessment, planning and intervention skills (Blocher, 1983). Finally, evaluation focused on client outcome as a more telling measure of the supervision approach.

The conjoint supervision model developed for the PACT program integrates components of group supervision (Sansbury, 1982), co-facilitation (Pfeiffer & Jones, 1975), dual-focus (McBride & Martin, 1986), the collaborative team (Sperling, et al., 1986) and a case-presentation format (Biggs, 1988). Conjoint supervisors have equal rank, responsibility and consistently work together as cosupervisors. One critical difference is the division of certain supervisory responsibilities. The Counseling Center therapist has primary responsibility for client well-being, while the Psychology Department supervisor maintains major responsibility for monitoring the professional development and personal growth of trainees. In practice, both supervisors exercised overlapping

contacts with both clients and trainees and thus shared overlapping concerns with client care and trainee welfare. This framework is represented in Figure 1.

Insert Figure 1 about here

Additional supervisory functions are provided by student coordinators selected from a pool of experienced companion-therapists who have completed one semester of PACT internship. The student coordinators organize initial training, lead weekly progress meetings, provide as-needed peer support and first-line contact for trainees in crisis. They undertake certain administrative tasks such as record-keeping, scheduling, and organization of training materials. The coordinators also maintain therapeutic liaison between trainees and supervisors ("please get in touch with ...", or "you should know that ...").

After initial screening, selection and training, each trainee is paired with a volunteer client being seen concurrently in intensive group psychotherapy with the primary therapist/clinical care supervisor. Each trainee then attends the weekly progress meeting of all trainees, led by the student coordinators, and a weekly case supervision meeting co-facilitated by both professional supervisors with a maximum of six trainees per supervision group.

During their initial training, trainees are instructed in the use of the clinical case presentation format. The trainee then reports and evaluates CT/client contacts during the preceding week and the progress of the client relative to the therapeutic goals previously established. Treatment goals are determined through a collaborative process with input from supervisors, student coordinators and trainees. A written record of treatment goals and client progress is kept.

While both supervisors provide expert guidance and bring to bear their individual experience and orientation, the division of supervision responsibilities allows a special focus for each: the counseling center therapist oversees delineation of goals and directions to encourage client change and maintain client welfare; the professional development supervisor assumes primary responsibility to monitor and process trainee responses to the trainee-client relationship and the ongoing experience of the trainee. Throughout, feedback and support are provided from both directions ("your client is certainly thriving . . .", "you've had some very creative ideas"). The case presentation approach provides a format which encourages trainees to make precise observations, to think in a strategic and evaluative manner and to engage together with their peers and supervisors in consideration of client dynamics and treatment planning. A comprehensive case study was required of each trainee at the end of the semester.

The weekly progress meetings facilitated by the student coordinators provide an additional ventilation and support system for trainees and a further opportunity to monitor trainee-client interaction. The meetings are also used for additional skill development.

Figure 1 illustrates the structure of the supervision program which optimizes a multiple feedback system. These trainees learn to provide clinical feedback to other trainees and to accept supervisory direction from both their peers and the professionals. The information flow from the client, through the trainee, to the primary care therapist enhances client monitoring and the professional development of the student/trainee. It is this collaborative process which appears to significantly enhance treatment.

Evaluation

Subjects

Companion therapy trainees were assigned to 88 eating disorder clients presenting for treatment at the Counseling Center over a five year period. Trainees were undergraduate students majoring in psychology. Sixty-five women and 27 men served as PACT interns.

Instruments

Client and trainee perceptions of client change were assessed using a PACT Change Scale (Potter, Kirk, & Lenihan, 1984) after the completion of each semester of treatment. This instrument

rates the degree of client change from unproductive to productive using a seven point Likert scale ranging from one (unproductive change) to seven (productive change). Four on the scale represents no change. The scale was designed to evaluate perceived changes in self-efficacy, attitudes, and relationships. Of the trainee/client pairs, 75 clients and 69 trainees completed the scale.

Clients in the program also completed pre- and post-treatment psychological measures and reports of critical behavioral incidents. The Compulsive Eating Scale (CES) (Dunn & Ondercin, 1981) measures eating practices and associated emotional variables and produces scores ranging from 16 to 80 with the higher scores reflecting greater disturbance in eating patterns. Rigid perfectionistic traits and over-dependence on the expectations of others were tested with the Perfectionism Scale (Burns, 1980), consisting of 10 items scored from -20 to +20 with higher scores suggesting perfectionism. Femininity/masculinity ambiguities were reflected in the Bem Sex Role Inventory (SRI) (Bem, 1974) which yields a femininity (F) and a masculinity (M) score. A difference score (F - M) was calculated as a measure of exaggerated femininity. Lower scores represent orientation toward androgyny (SRI-A).

Method

Paired t-tests were used to test any significant differences between a client's self-rating and the trainee's rating on Change

Scale dimensions. The same statistical analysis was used to test for pre-post differences on the psychological and behavioral measures of client change. Data on the latter has been analyzed only for the first term of treatment to eliminate cumulative outcome effects. Pairing trainee/client ratings and pairing each client's pre-post measures offers a more rigorous test of actual differences than would testing for mean differences.

A traditional one-to-one supervision group was not available for comparison purposes.

Insert Figure 2 about here

Results

Client change ratings for paired PACT Change Scales are presented in Figure 2. Of the trainee/client pairs, 59 paired protocols were available. Reports of change by clients and trainees were uniformly rated as positive. Among the self-efficacy items the highest client ratings were registered on the item measuring attitudes toward the presenting problem ($\bar{X}$ = 6.00). Clients also rated their self-control and eating behavior in highly productive ways. Their relationship with the primary therapist and their companion-therapist (trainee) was also highly rated. Change in the relationship with parents, although still positive, was rated comparatively the lowest ($\bar{X}$ = 4.92).

Trainee ratings of their client's change were similarly positive on most items; however, there were some differences. Trainees rated client change significantly lower on self-confidence ($t = 1.74$, $p = .09$) and client use of self-help techniques ($t = 1.65$; $p = .10$). Trainees also rated their client less positively on self-control, attitude toward presenting problem, and attitude toward self.

In rating the client/trainee relationship variables, the trainees judged these dimensions more positively than did their clients. Most significant was the rating difference on the overall satisfaction item ($t = -2.23$, $p = .03$).

Insert Table 1 about here

Table 1 presents the results of the responses to the pre- and post-treatment measures of the clients. The most significant changes were registered with the compulsive eating and perfectionism measures. Self-reported changes in critical eating behaviors were also significantly positive. Binges declined by 37%, purges by 40%, and skipped meals by 24%.

Nonsig[illegible]ant but directional changes were noted on the Bem Sex Role Inv[illegible]ory. This change is due almost entirely to the decline on the femininity (F) score. The pre- and post-treatment data is illustrated in Figure 3.

Insert Figure 3 about here

Discussion

Rather than the usual focus on basic facilitative interpersonal skills as a measure of supervision effectiveness, the authors have chosen to follow the recommendations of Kagan (1983) and Lambert (1980) in using client outcome data to assist in evaluating the described model of conjoint supervision. While supervisee growth and change are clearly important goals, it is the therapeutic interaction with a genuine client that clearly differentiates supervision from counseling skills training (Holloway & Hosford, 1983). Client progress can reliably signal trainee effectiveness. This treatment/training program was made available without condition to any eating disordered client meeting the diagnostic criteria and to any trainees who requested. Because of high interest and participation, no control group was available for comparison purposes. This obviously limits the conclusions that can be drawn from the data presented.

Both the direct sampling of client and intern perceptions of change and the objective measures of client change have helped to validate the impact of trainee interaction with statistically significant positive changes. Interestingly, while these trainees rate their clients as making notable productive changes, the clients, as a group, perceive their own outcome, particularly

their self-management and self-esteem variables, significantly more positively than do their own companion-therapists. Perhaps these changes in control and confidence are experienced more phenomenologically than they are perceived by their observing companion-therapists. It has been our experience that many eating disordered people experience vast relief with the onset of self-control and with dawning awareness that their difficulties are solvable. Because they are making some progress, these clients may experience their "glass half-full" (actually 75% full according to this data); whereas their companion-therapists/ trainees focus on progress that is yet to be accomplished. From the trainee's viewpoint, then, their client is still "half empty."

In contrast, while the clients are uniformly positive in rating their relationship with their CTs, the trainees themselves rate these dynamics in even rosier light. This difference in ratings of the trainee-client relationship dynamics corresponds with some previous reports that ratings by therapists tend to be more favorable than other measures (Garfield, Prager, & Bergin, 1971; Hortenstein, Houston, & Holmes, 1973). The most significant difference in these change scale ratings was registered in the overall satisfaction with the companion-therapy experience. The trainees' highly positive rating of these interpersonal qualities, coupled with their relative disappointment in the behavioral change progress of their clients, raises some interesting questions regarding reliance on therapists' assessment of client

change as a sole measure of client progress, especially when the therapist is, professionally, a beginner.

The objective pre-post measures used in this study also confirmed positive client outcome. Significantly positive decreases in the Compulsive Eating Scale scores and in negative eating behaviors were the most dramatic. Perfectionism, a measure of rigidity and externalized self-regulation, also declined significantly. This decline is congruent with the Change Scale increases in self-confidence and self-acceptance. The one measure which remained relatively unchanged is the Sex Role Identity scale. Here there is noticeable but non-significant change in androgyny. Certainly this area of change is at a more subtle personality level and may occur over a lengthier period of time. After but one semester of treatment, any indication of a decline in "ultra" feminine self-description can be interpreted as positive.

In addition to this positive client outcome data, an abundance of more subjective experience, personal observation, and trainee feedback has suggested a number of special advantages for trainees and supervisors. Kagan (1983) has recommended supervision "in which different counselor needs are met by different procedures" (p. 69). Conjoint supervision provides just such a variety. The emotional pressures felt by these beginners were met in progress meetings, clinical case supervision meetings, or requested one-to-one sessions with either supervisor. Having

choice and variety in these configurations suited divergent trainee needs, particularly for those with severely affected clients. The need for professional development was met in ongoing inservice meetings. Such inservice sessions included skill development in relaxation training, cognitive modification, nutritional counseling, and crisis intervention. Progress meetings apart from professional supervision, peer review, and peer support appear to reduce supervisee fear and shame (Alonso & Rutan, 1988) and resistance to the supervision process (Liddle, 1986). The case presentation group format noticeably enhances trainees' observational, information-processing, and therapeutic planning skills. Finally, trainees benefit from exposure to supervisory styles which provide opportunities to observe two distinct, yet complementary orientations. Supervisor collaboration also modeled professional cooperation and demonstrated the importance of working together for client benefit.

The professional supervisors have discovered a number of advantages. Collaboration has helped to counter the myth that one supervisor "can do it all" (Kagan, 1983; McCarthy, DeBell, Kanuha, & McLeod. 1988). This format not only distributes the many demanding tasks of supervision, but also structures a division of responsibility that lessens the role conflict inherent in balancing the competing needs of a vulnerable trainee and those of a needy client. One supervisor's strengths and weaknesses are

more easily expressed when the complementary attributes of an equal co-supervisor are available. Scheduling supervision and other time demands were more efficiently met. Finally, with the conjoint model, concerns regarding ethical standards for supervision (McCarthy, et al., 1988) are satisfied without conflict of interest. Liability for the trainee's clients is clearly a responsibility of the client care supervisor, while the responsibility for certifying the competence of the trainee is assumed by the professional development supervisor. From each of these standpoints, conjoint supervision is more efficient and more comprehensive supervision.

Leddick and Dye (1987) have reported that trainees expect a highly structured learning experience with clear goals, specific evaluation, and feedback; but they also want supervisors who are flexible, patient and who value them as independent persons. The sharing of these multidimensional training tasks helps to dissipate any overburden confronting the supervisor responsible for a number of individual beginning supervisees. Sharing also avoids the "do-it-my-way" apprenticeship pitfalls of one-to-one supervision (McBride & Martin, 1986). Dividing ultimate responsibility has tended to clarify these roles for both co-supervisors as well as trainees and clients. The client care supervisor can suggest a specific set of interventions with the client, while the professional development supervisor can work with the trainee's own feelings and personal reactions to the

experience. Both supervisory inputs are oriented toward growthful change for all concerned, but from two different directions rather than one direction at the expense of the other. It is our experience that regular consultation between supervisors who enjoy a mutual respect has facilitated the blending of styles that is so critical to this model.

Although this conjoint framework was devised to implement a specific treatment/training program and has been applied with undergraduate trainees, the approach can be adapted to other treatment settings and varied trainee populations. The authors believe that the conjoint aspects of this model would present some clear advantages especially for supervision of graduate level trainees shuttling between on-campus academic and on-site clinical supervision.

The outcome data reported here have established that clients do progress in the care of these trainees. In addition, our observations are that, with conjoint supervision, beginners become more sophisticated providers in an atmosphere which teaches them to think in an evaluative and strategic manner, to contribute to treatment planning, to carry forth planned interventions, and to care for their clients and recognize client progress. The conjoint framework pairs two professionals of equal power with distinctive differentiating supervisory roles, allowing a balance of concern for client well-being with attention to trainee growth. When both foci are blended in consistent, ongoing, case-

presentation oriented group supervision, then all participants--clients, trainees and supervisors--prosper in remarkable ways.

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Figure 1 Conjoint Supervision Model

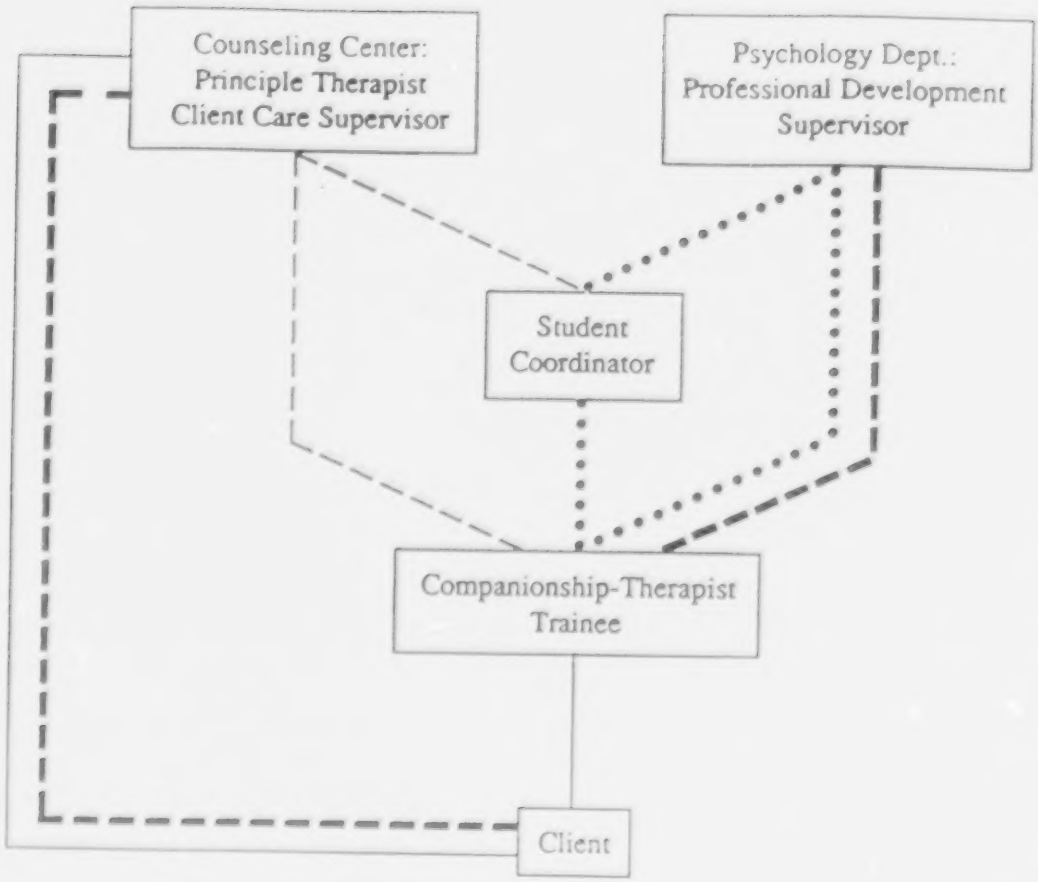


Figure 2

Client Change Ratings
by
Clients and Trainees

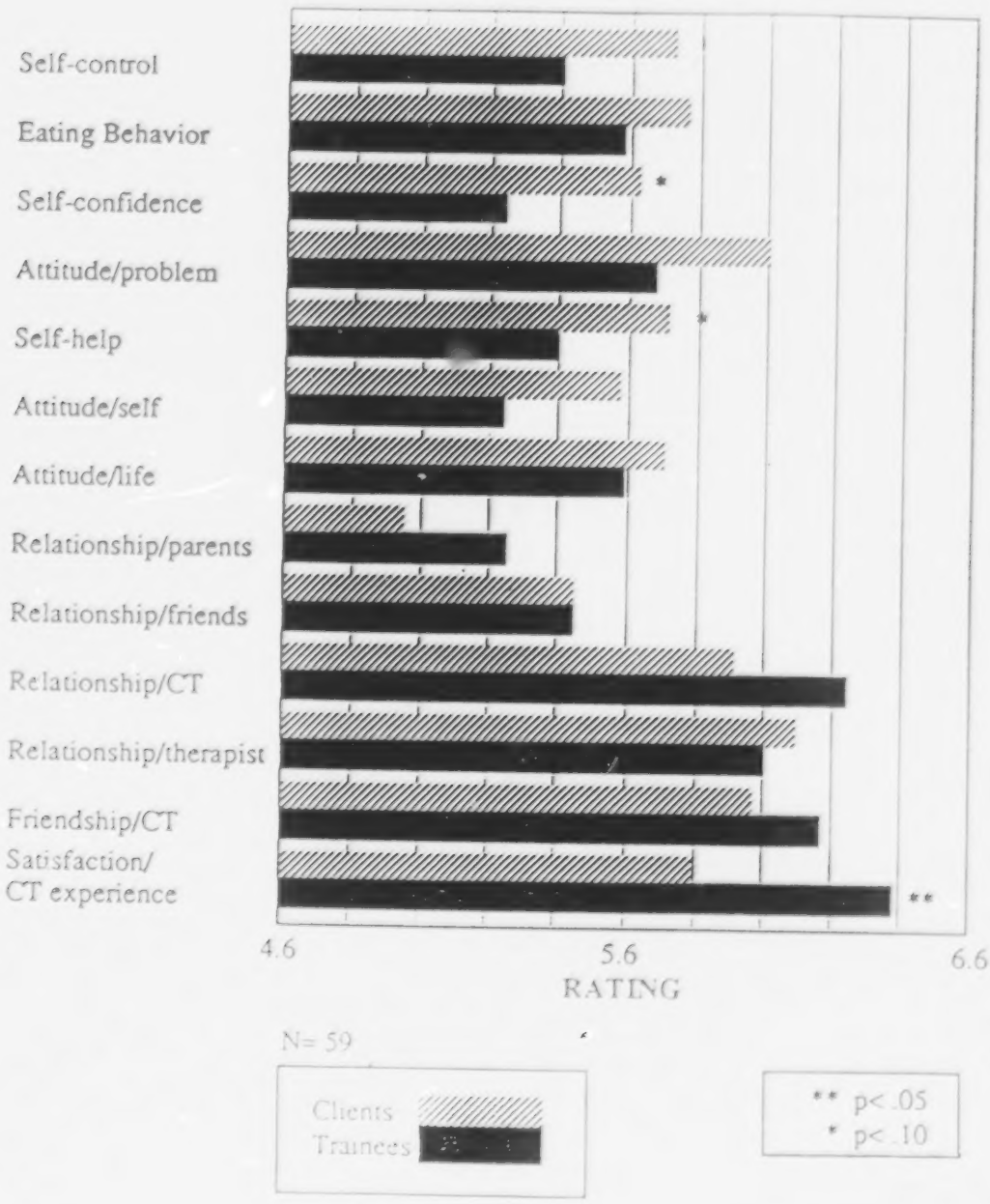


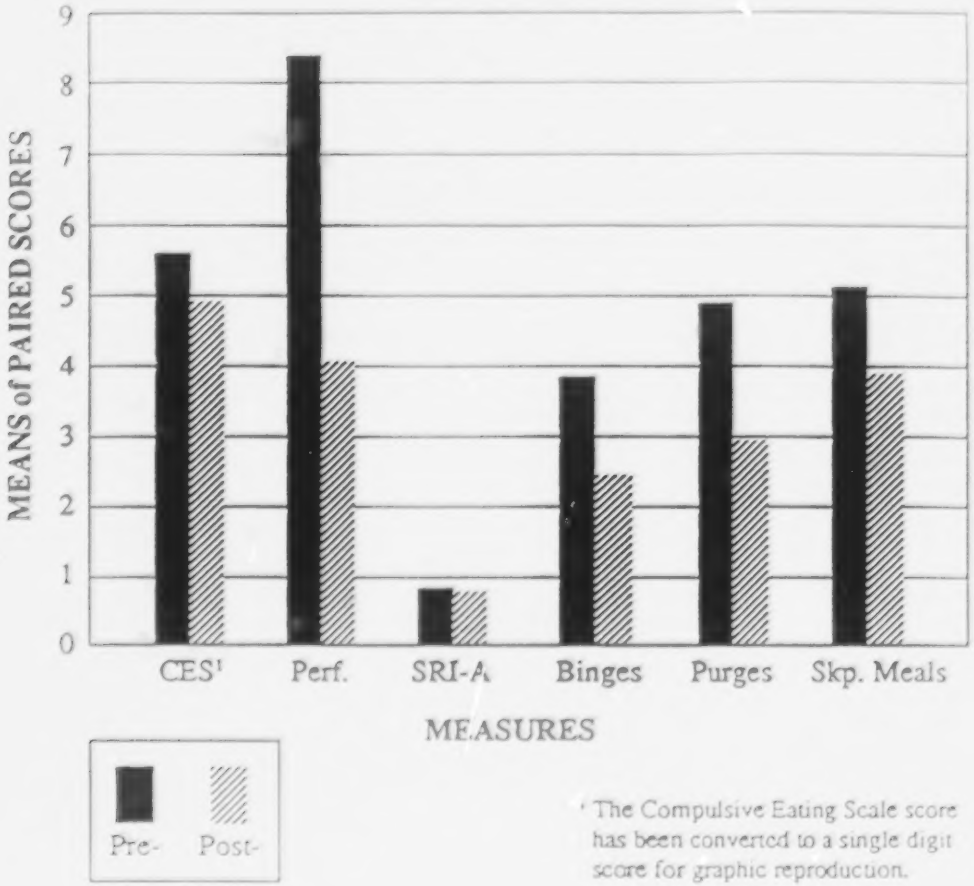
Table 1 Comparisons of Pre- and Post-Treatment Measures

	MEANS of PAIRED SCORES		
	Pre-Treatment	Post-Treatment	t(53)
Compulsive Eating	56.09	49.37	3.85***
Perfectionism	8.39	4.07	4.88***
Sex Role Inventory			
Masculinity	4.33	4.31	0.28
Femininity	5.18	5.09	1.46
Androgyny	0.89	0.80	0.81
Binges/Week	3.89	2.46	1.81*
Purges/Week	4.91	2.96	2.86**
Skipped Meals/Week	5.15	3.93	1.39

*** p< .001
** p< .01
* p< .1

N= 54

Figure 3 Pre-Treatment and Post-Treatment Comparisons



[1] The Compulsive Eating Scale score has been converted to a single digit score for graphic reproduction.

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